DEVELOPMENTAL DISABILITIES

Missouri Department of Mental Health

DIVISION OF DEVELOPMENTAL DISABILITIES

Missouri Department of Mental Health
Office of Licensure & Certification

Application for **Licensure** - Instructions

- Please complete and return all applications promptly. **You must return the completed application at least 90 days prior to the expiration date of your license.**

- Before we can accept your application for processing, it must be complete. **The application will be returned to you requesting inclusion of any missing information.** If a section is not applicable to your agency/facility, please note that with an N/A in those sections. Print clearly and legibly using black ink or type.

- The Application for Licensure is now available online at the following websites http://dmh.mo.gov/dd/provider/ or http://dmh.mo.gov/dd/forms.html. The online form allows you to fill it in electronically, print it, sign it with an original signature, and have it notarized.

- If you want to request more than one facility or program to be licensed, there is space on Page 2 of the application to list the additional facilities or programs.

- Clearly check **ALL** the programs applicable to your licensure on Page 2 of the application.

- For **initial** applications:
  - Submit a floor plan of the facility with a narrative of how each room is to be used;
  - Include your staffing pattern, indicating the number of direct care staff on duty during each shift Monday through Sunday.

- If you are requesting **renewal** of your annual license:
  - If you are *remodeling* or *changing the structure* and *use of your building*, include a floor plan of the facility with a narrative indicating how each room is to be used;
  - It is not necessary to submit your staffing pattern, unless it has changed within the last licensure cycle.

- **Fees:** Enclose the following license fee for each facility/agency to be licensed under this application.
  - For facilities/agencies with three (3) or fewer residents/participants, no fee;
  - For facilities/agencies having at least four (4), but fewer than 10 residents/participants--$10.00;
  - For facilities/agencies having 10 or more residents/participants--$50.00;
  - For facilities that are licensed by the Department of Health and Senior Services (DHSS), the Department of Mental Health (DMH) licensure fee is based upon the licensed capacity determined by DHSS, not the number of DMH clients residing in the facility.

- **Secretary of State Registration:**
  - To determine if registration is required, go to the Secretary of State website: www.sos.mo.gov.
  - To find Charter # and Expiration Date, go to https://bsd.sos.mo.gov/BusinessEntity/BESearch.aspx?SearchType=0

- **Fire/Safety Inspections:**
  - Send proof of payment, if paid by means other than city/county taxes, for fire coverage of all sites served by a volunteer or subscription fire department;
  - **After processing** your completed NOTARIZED application and fee, if a request for fire/safety inspection is required, the Office of Licensure and Certification will submit the request to the State Fire Marshal's office. Those required are:
    - All *residential programs*, except those dually licensed by the DHSS and DMH, must have an approved fire inspection from the State Fire Marshal. This includes group homes for the mentally ill and/or developmentally disabled, family living arrangements and semi-independent living arrangements.
    - All *day programs* serving the mentally ill and/or developmentally disabled must have an approved fire inspection from the State Fire Marshal.

- **Conviction of Felony**
  - For any persons named on the application with a felony background, submit an explanation.

- **Mail your COMPLETED application packet, which includes the NOTARIZED application and correct licensure fee, to:**

Missouri Department of Mental Health
Office of Licensure and Certification
PO Box 687
Jefferson City, MO 65101

NOTE: Obtaining a DMH license *does not* guarantee funding or placement of DMH consumers.

If you have questions regarding your licensure application, please contact **Judy Scheulen**, Office of Licensure and Certification, at (573) 751-4024.

Save Print Reset

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
1706 E. ELM STREET, P.O. BOX 687
JEFFERSON CITY, MISSOURI 65102

APPLICATION FOR LICENSURE

DMH USE ONLY	
FEE RECEIPT #	FEE AMOUNT
IDENTIFIER	

NAME OF AGENCY/PROGRAM	TELEPHONE NUMBER	FAX NUMBER

FOR PROFIT	NOT FOR PROFIT	GOVERNMENT
☐ Corporation ☐ Individual	☐ Corporation ☐ Charitable	☐ City ☐ County ☐ District
☐ Partnership ☐ Privately Owned	☐ Church Affiliate	☐ State ☐ Veteran Administration
☐ Other (specify) _____	☐ Other (specify) _____	☐ Other (specify) _____

NAME OF DIRECTOR OR FOSTER PARENT	TITLE	COUNTY	EMPLOYER TAX ID NO. OR SOCIAL SECURITY NO.

ADDRESS OF AGENCY/PROGRAM (PHYSICAL LOCATION)	CITY	STATE	ZIP CODE

BILLING/MAILING ADDRESS	CITY	STATE	ZIP CODE

CONTACT PERSON OF AGENCY/PROGRAM	TELEPHONE NUMBER	TITLE

E-MAIL ADDRESS	WEB SITE

GOVERNING BODY PRESIDENT	ADDRESS	CITY	STATE	ZIP CODE

NAME OF CORPORATE OWNER, IF APPLICABLE

ADDRESS OF CORPORATE OWNER	CITY	STATE	ZIP CODE

SECRETARY OF STATE REGISTRATION	CHARTER #	EXPIRATION DATE
☐ YES ☐ NO IF YES, WHAT IS YOUR CHARTER # AND EXPIRATION DATE?		

FIRE SAFETY: IS THE RESIDENTIAL OR DAY PROGRAM SITE(S) SERVED BY A VOLUNTEER FIRE ASSOCIATION OR SUBSCRIPTION FIRE DEPARTMENT?

☐ YES ☐ NO IF YES, ATTACH DOCUMENTATION OF CURRENT CONTRACT OR PROOF OF MEMBERSHIP FOR EACH SITE.

HAS ANY PERSON NAMED ON THIS APPLICATION BEEN CONVICTED OF A FELONY?

☐ YES ☐ NO IF YES, PLEASE SUBMIT EXPLANATION ON A SEPARATE PAGE.

OTHER LICENSING, CERTIFYING OR ACCREDITING BODY (NON-DMH) (EXAMPLES: DHSS, DESE, CARF, COA, ETC.)	FACILITY/PROGRAM TYPE	EFFECTIVE DATE	EXPIRATION DATE

ARE YOU REQUESTING LICENSURE FOR ADDITIONAL FACILITIES OR PROGRAMS UNDER THIS APPLICATION

☐ YES ☐ NO IF SO, PLEASE LIST BELOW:

NAME OF AGENCY/PROGRAM	TELEPHONE NUMBER	FAX NUMBER		
ADDRESS	CITY	STATE	ZIP CODE	COUNTY
E-MAIL ADDRESS	WEB PAGE	NAME & TITLE OF CONTACT PERSON		

OTHER LICENSING, CERTIFYING OR ACCREDITING BODY (NON-DMH)	FACILITY/PROGRAM TYPE	EFFECTIVE DATE	EXPIRATION DATE

NAME OF AGENCY/PROGRAM	TELEPHONE NUMBER	FAX NUMBER		
ADDRESS	CITY	STATE	ZIP CODE	COUNTY
E-MAIL ADDRESS	WEB PAGE	NAME & TITLE OF CONTACT PERSON		

OTHER LICENSING, CERTIFYING OR ACCREDITING BODY (NON-DMH)	FACILITY/PROGRAM TYPE	EFFECTIVE DATE	EXPIRATION DATE

NAME OF AGENCY/PROGRAM	TELEPHONE NUMBER	FAX NUMBER		
ADDRESS	CITY	STATE	ZIP CODE	COUNTY
E-MAIL ADDRESS	WEB PAGE	NAME & TITLE OF CONTACT PERSON		

OTHER LICENSING, CERTIFYING OR ACCREDITING BODY (NON-DMH)	FACILITY/PROGRAM TYPE	EFFECTIVE DATE	EXPIRATION DATE

ARE THERE ANY PROGRAMS OF YOUR AGENCY FOR WHICH YOU ARE NOT REQUESTING LICENSURE?

☐ YES ☐ NO IF YES, PLEASE EXPLAIN WHY:

IS THE FACT THAT NOT ALL PROGRAMS OF YOUR AGENCY ARE LICENSED MADE CLEAR TO INDIVIDUALS RECEIVING THOSE SERVICES?

☐ YES ☐ NO HOW IS THIS DONE? ______________________________ (PLEASE SUBMIT A COPY OF YOUR AGENCY'S BROCHURE FOR REVIEW.)

CHECK ALL PROGRAMS FOR WHICH APPLICATION IS BEING MADE AND INDICATE CAPACITY WHERE NOTED.

☐ Family Living Arrangement/Treatment Family Home (MI/MD) – Capacity __________	☐ ICF – Capacity __________ ☐ Group Home (MI) – Capacity __________
☐ Family Living Arrangement (DD) – Capacity __________	☐ Group Home (DD) – Capacity __________
☐ RCF – Capacity __________	☐ Semi-Independent Living Arrangement – Capacity __________
☐ SNF – Capacity __________	☐ Day Program (MI) – Capacity __________
☐ ICF/ID – Capacity __________	☐ Day Program (DD) – Capacity __________

ACKNOWLEDGEMENT

MISSOURI

CITY OF _____

COUNTY OF _____

_____ and _____
GOVERNING BODY PRESIDENT — CHIEF ADMINISTRATIVE OFFICER

being duly sworn to me on his/her oath, deposes and says that he/she has read the foregoing application and that the statements contained therein are true and correct to the best of his/her knowledge; and further gives assurance of the ability and intention of _____ to comply with the laws applicable to licensed and certified facilities and the regulations
NAME OF APPLICANT OR AGENCY

established thereunder. It is understood that _____
NAME OF APPLICANT OR AGENCY

will be eligible for licensure or certification only after it has complied with the requirements of the law and the regulations and codes, and that such licensure or certification is subject to revocation at any time this agency fails to comply with the law, regulations and codes. Furthermore, it is agreed that agents of the Department of Mental Health are authorized by law to make inspections of the premises, talk to employees, residents or clients about the operation of the facility, and to audit the financial records of this agency.

_____ and _____ further certify that he/she will comply with
GOVERNING BODY PRESIDENT — CHIEF ADMINISTRATIVE OFFICER

all requirements, corrections and/or improvements in _____
NAME OF APPLICANT OR AGENCY

contained in the survey reports completed by the authorities of the Department of Mental Health and submitted to said program.

SIGNATURE (PRESIDENT)	SIGNATURE (CHIEF ADMINISTRATIVE OFFICER)

NOTARY INFORMATION

NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE		COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR		**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		